Simi West Dental Group
805-577-7733
1105 Red Tail Way
Simi Valley, CA 93065

***** How did you hear about our office?** _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ◯ Policy Holder Preferred Name: _____

◯ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondences via e-mail.

Other Phone: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Ins. Company: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Ins. Company: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

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MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯Yes	◯No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	◯Yes	◯No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯Yes	◯No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯Yes	◯No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯Yes	◯No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes	◯No	_____
Are you on a special diet?	◯Yes	◯No	
Do you use tobacco?	◯Yes	◯No	
Do you use controlled substances?	◯Yes	◯No	

Women: Are you
Pregnant/Trying to get pregnant? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No Nursing? ◯Yes ◯No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs

☐Other If yes, please explain _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯Yes	◯No	Cortisone Medicine	◯Yes	◯No	Hemophilia	◯Yes	◯No	Radiation Treatments	◯Yes	◯No
Alzheimer's Disease	◯Yes	◯No	Diabetes	◯Yes	◯No	Hepatitis A	◯Yes	◯No	Recent Weight Loss	◯Yes	◯No
Anaphylaxis	◯Yes	◯No	Drug Addiction	◯Yes	◯No	Hepatitis B or C	◯Yes	◯No	Renal Dialysis	◯Yes	◯No
Anemia	◯Yes	◯No	Easily Winded	◯Yes	◯No	Herpes	◯Yes	◯No	Rheumatic Fever	◯Yes	◯No
Angina	◯Yes	◯No	Emphysema	◯Yes	◯No	High Blood Pressure	◯Yes	◯No	Rheumatism	◯Yes	◯No
Arthritis/Goul	◯Yes	◯No	Epilepsy or Seizures	◯Yes	◯No	High Cholesterol	◯Yes	◯No	Scarlet Fever	◯Yes	◯No
Artificial Heart Valve	◯Yes	◯No	Excessive Bleeding	◯Yes	◯No	Hives or Rash	◯Yes	◯No	Shingles	◯Yes	◯No
Artificial Joint	◯Yes	◯No	Excessive Thirst	◯Yes	◯No	Hypoglycemia	◯Yes	◯No	Sickle Cell Disease	◯Yes	◯No
Asthma	◯Yes	◯No	Fainting Spells/Dizziness	◯Yes	◯No	Irregular Heartbeat	◯Yes	◯No	Sinus Trouble	◯Yes	◯No
Blood Disease	◯Yes	◯No	Frequent Cough	◯Yes	◯No	Kidney Problems	◯Yes	◯No	Spina Bifida	◯Yes	◯No
Blood Transfusion	◯Yes	◯No	Frequent Diarrhea	◯Yes	◯No	Leukemia	◯Yes	◯No	Stomach/Intestinal Disease	◯Yes	◯No
Breathing Problem	◯Yes	◯No	Frequent Headaches	◯Yes	◯No	Liver Disease	◯Yes	◯No	Stroke	◯Yes	◯No
Bruise Easily	◯Yes	◯No	Genital Herpes	◯Yes	◯No	Low Blood Pressure	◯Yes	◯No	Swelling of Limbs	◯Yes	◯No
Cancer	◯Yes	◯No	Glaucoma	◯Yes	◯No	Lung Disease	◯Yes	◯No	Thyroid Disease	◯Yes	◯No
Chemotherapy	◯Yes	◯No	Hay Fever	◯Yes	◯No	Mitral Valve Prolapse	◯Yes	◯No	Tuberculosis	◯Yes	◯No
Chest Pains	◯Yes	◯No	Heart Attack/Failure	◯Yes	◯No	Osteoporosis	◯Yes	◯No	Tumors or Growths	◯Yes	◯No
Cold Sores/Fever Blisters	◯Yes	◯No	Heart Murmur	◯Yes	◯No	Pain in Jaw Joints	◯Yes	◯No	Ulcers	◯Yes	◯No
Congenital Heart Disorder	◯Yes	◯No	Heart Pacemaker	◯Yes	◯No	Parathyroid Disease	◯Yes	◯No	Venereal Disease	◯Yes	◯No
Convulsions	◯Yes	◯No	Heart Trouble/Disease	◯Yes	◯No	Psychiatric Care	◯Yes	◯No	Yellow Jaundice	◯Yes	◯No

Have you ever had any serious illness not listed above? ◯Yes ◯No _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE:** _____

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PATIENT DENTAL HISTORY

Patient Name: _____

Name of Previous Dentist and Location: _____

Date of Last Exam: _____

1.	Do your gums bleed while brushing or flossing?	○ Yes	○ No
2.	Are your teeth sensitive to hot or cold liquids/foods?	○ Yes	○ No
3.	Are your teeth sensitive to sweet or sour liquids/food?	○ Yes	○ No
4.	Do you feel pain on any of your teeth?	○ Yes	○ No
5.	Do you have any sores or lumps in or near your mouth?	○ Yes	○ No
6.	Have you had any head, neck, or jaw injuries?	○ Yes	○ No
7.	Have you ever experienced any of the following problems in your jaw?	○ Yes	○ No
	• Clicking	○ Yes	○ No
	• Pain (joint, ear, side of face)	○ Yes	○ No
	• Difficulty in opening or closing	○ Yes	○ No
	• Difficulty in chewing	○ Yes	○ No
8.	Do you have frequent headaches?	○ Yes	○ No
9.	Do you clench or grind your teeth?	○ Yes	○ No
10.	Do you bite your lips or cheeks frequently?	○ Yes	○ No
11.	Have you ever had difficulty during tooth extractions in the past?	○ Yes	○ No
12.	Do you wear partial or full dentures?	○ Yes	○ No
	If yes, date of placement: _____		
13.	Have you ever had Orthodontic treatment (Braces)?	○ Yes	○ No
14.	Have you ever received oral hygiene instruction regarding the care of your teeth and gums?	○ Yes	○ No
15.	Have you had periodontal treatment (deep cleaning)?	○ Yes	○ No
16.	Date of last x-rays: _____		

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COSMETIC QUESTIONNAIRE

With the recent advancements in materials and techniques, many of our patients are asking more questions about cosmetic dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

Patient Name: _____ Date: _____

Do you like the appearance of your teeth?	◯ Yes	◯ No
Are your teeth as straight as you would like them to be?	◯ Yes	◯ No
Do you think you have a "gummy" smile?	◯ Yes	◯ No
Are you happy with the length, width, and shape of your teeth?	◯ Yes	◯ No
Do you have any chipped teeth?	◯ Yes	◯ No
Do you have any missing teeth?	◯ Yes	◯ No
Do you have any spaces between your teeth?	◯ Yes	◯ No
Do you have any discoloration, stains, or spots on your teeth?	◯ Yes	◯ No
Would you like for your teeth to be whiter?	◯ Yes	◯ No
Do you have any dental work that you don't like?	◯ Yes	◯ No
Do you have any silver fillings that you would like changed to white?	◯ Yes	◯ No
Has anyone you've known had any cosmetic dentistry done that interests you?	◯ Yes	◯ No

If there was anything else you could change about the appearance of your teeth, what would it be?

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FINANCIAL POLICY

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive treatment. Please understand that payment for services rendered are part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

- Full payment is due at time of service for non-insurance patients.
- We accept cash, checks, Visa/MasterCard, American Express and Discover.
- If you have dental insurance, you are expected to pay our estimated portion, all copays, or deductibles at the time of service.
- We offer a no interest or extended payment plan (Care Credit) upon approved credit.
- We reserve the right to charge $75 (per scheduled hour) for appointments that are missed or canceled without a 48-hour notice.
- A fee of $25 will be charged for all returned checks.

_____
(Initials)

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left towards your maximum, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what is usual and customary, you are responsible for payment.

We will accept assignment of insurance benefits. You will be expected to pay your estimated portion of the fee for treatment. **Be aware that this is only an estimate.** The actual amount could vary depending on what your insurance will cover or unexpected changes of treatment. You are ultimately responsible for any balance for services rendered. We cannot bill your insurance company unless you give us your insurance information. This information must be provided before treatment begins. Your insurance policy is a contract between your employer and your insurance begins. Your insurance policy is a contract between your employer and your insurance company. We are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance will show on your monthly statement.

_____
(Initials)

I have read, understand and agree to the above terms.

Print patient name: _____

Signature: _____ Date: _____
(patient, parent, or guardian)

* If submitting via email, signature will be obtained at the time of your appointment. Thank You!

Submit Forms

Cancellation and Broken Appointment Policy

Our number one priority is your dental health. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When a patient fails to keep their appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

- Cancellation or rescheduling of an appointment ***with 48 hours or more*** notification-***no charge*** Cancellation or rescheduling of an appointment ***less than 48 hours*** will be considered a broken appointment.
- Broken appointment may be charged a fee of $75.00 per scheduled hour if we are unable to fill appointment. This fee cannot be billed to your insurance.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

Thank you for your understanding.

Simi West Dental Group

I have read and understand the above mentioned policy.

_____

Print Patient First and Last Name.

_____ _____

Patient signature (Parent or Guardian if minor) Date

Notice of Privacy Practices

Effective Date: January 1, 2016

The following describes how health information about you may be used and disclosed and how you can get access to this information.

LEGAL

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices. While we reserve the right to change our practices at any time, provided alterations are permitted under the applicable law, changes must be noted in a revised Notice and made available to you. You may request a copy of our Notice at any time.

USES & DISCLOSURES OF HEALTH INFORMATION

Treatment: We may share information with physicians or other health care providers treating you.

Payment: We may disclose to obtain payment for services we provide.

Healthcare Operations: We may disclose in connection with assessment, review of competence or qualifications, evaluation of practitioner and provider performance, and in conducting of training, accreditation, certification, licensing or credentialing.

Your Authorization: You, of course, can give us consent to release information to anyone for any purpose. This includes friends and family. We cannot release information to them without your consent. This consent can be revoked at any time.

Persons Involved In Care: We may disclose information to notify, or assist in the notification of a family member, your personal representative or another person responsible or involved in your care. If present, you can object. However, if there is an emergency or incapacity, we will disclose based on professional judgment and our experience with common practice to make reasonable inferences in your best interest.

Marketing: We will not disclose for purposes of marketing communications without written consent.

Required by Law: We may disclose when required to do so by law.

Abuse or Neglect: We may disclose to authorities if we reasonably believe you are a possible victim of abuse, neglect, domestic violence, or other crimes or to avert serious threat to you and others' health or safety.

National Security: We may disclose to military authorities in the interest of national security and to correctional authorities or law enforcement officials under certain circumstances.

Appointment Reminders: We may disclose to provide you with appointment reminders (voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have a right to look at or get copies of your health information, with limited exceptions. Requests must be made in writing.

Disclosure Accounting: You have a right to know under what circumstances we have released information for purposes, other than those outlined in this Notice, covering the past six (6) years but not before January 1, 2010. You are entitled to one request per 12-month period without being charged.

Restriction and Amendment: You have a right to request additional restrictions on our use or disclosure of health information. You also have the right to amend that information (request must be in writing with an explanation). We are not required to agree to added restrictions and we may deny requests for amendments under certain circumstances.

Alternative Communication: You have the right to request (must be done in writing) that we communicate with you about your health information by alternative means to alternative locations.

QUESTIONS and COMPLAINTS

If you want more information about our privacy practices or have questions, concerns, or complains, please contact us.

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received a copy of Dr. Tenggren Dental Care's Notice of Privacy Policies.

_____ _____

Signature Date

OFFICE USE ONLY

On _____, an Acknowledgment of Receipt of Notice of Privacy Policies form was delivered. The form was not signed due to:

- ☐ Communication barriers which prevent acknowledgement
- ☐ An emergency which prevent acknowledgement
- ☐ A refusal to sign
- ☐ Other _____